Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
ANTIBIOTICS (INTRAVENOUS/INTRAMUSCULAR) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. SE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
35 Michigan St. NE Floor 2
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion**
145 Michigan St. NE Ste 5200
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave. NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Pennock Hospital**
1009 W Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 S 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0195

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Ste 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 26 Mile Rd. Ste 3300
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 W 7 Mile Rd. Ste 3000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Ste 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St. Joseph Ave. Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

Post-Acute Physician Following _____

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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ANTIBIOTICS (INTRAVENOUS/INTRAMUSCULAR) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

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Infusions:

Anticipated Infusion Date: _____ **ICD-10 Code with Description:** _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected:

☐ CBC w/ Differential
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ BMP
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ CMP
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ C Reactive Protein (CRP), Blood Level
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Creatine Kinase (CK) Level
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Sedimentation rate
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Antibiotic Trough Blood Level ☐ Amikacin ☐ Gentamicin ☐ Tobramycin ☐ Vancomycin
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Antibiotic Peak Blood Level ☐ Amikacin ☐ Gentamicin ☐ Tobramycin
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Additional lab order(s) _____
- ☐ Once
- ☐ Every visit
- ☐ _____

Hydration:

☐ Sodium chloride 0.9% _____ mL, IV, Administer over _____ minutes

Pre-medications:

☐ Acetaminophen (TYLENOL) PO Once ☐ 325 mg ☐ 500 mg ☐ 650 mg ☐1000 mg

☐ DiphenhydrAMINE (BENADRYL) PO Once ☐ 25 mg ☐ 50 mg

☐ Additional pre-medications: _____

Treatment:

Frequency:
- ☐ Once
- ☐ Every 24 hours
- ☐ Every _____ hours
- ☐ Every _____ days

Duration:
- ☐ # of treatments _____
- ☐ # of days _____
- ☐ Until date: _____

☐ Discontinue PICC – May remove PICC line at the end of treatment

Select Desired IV Antimicrobial for Infusion

Cephalosporins

☐ **CeFAZolin (ANCEF) IV**
- ☐ 500 mg ☐ 2 g
- ☐ 1 g ☐ 3 g
- ☐ 1.5 g

☐ **Cefepime (MAXIPIME) IV**
- ☐ 500 mg
- ☐ 1 g
- ☐ 2 g

☐ **Ceftaroline (TEFLARO) IV**
- ☐ 200 mg
- ☐ 400 mg
- ☐ 600 mg

☐ **CefTAZidime (FORTAZ) IV**
- ☐ 500 mg ☐ 2 g
- ☐ 1 g

☐ **CefTRIAXone (ROCEPHIN) IV**
- ☐ 1 g
- ☐ 2 g

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Carbapenems

☐ **Ertapenem (INVANZ) IV**
- ☐ 500 mg
- ☐ 1000 mg

☐ **Meropenem (MERREM) IV**
- ☐ 500 mg ☐ 2 g
- ☐ 1 g

Glycopeptides

☐ **Dalbavancin (DALVANCE) IV**
- ☐ 500 mg
- ☐ 1000 mg
- ☐ 1500 mg

☐ **Oritavancin (KIMYRSA)**
- ☐ 1200 mg

☐ **Vancomycin (VANCOCIN) IV**
- ☐ 500 mg ☐ 1250 mg ☐ 2000 mg
- ☐ 750 mg ☐ 1500 mg ☐ 2250 mg
- ☐ 1000 mg ☐ 1750 mg ☐ 2500 mg

Aminoglycosides

☐ **Amikacin (AMIKIN) IV**
- ☐ 5 mg/kg
- ☐ 7.5 mg/kg
- ☐ 10 mg/kg

☐ **Gentamicin (GARAMYCIN) IV**
- ☐ 1 mg/kg ☐ 5 mg/kg
- ☐ 1.5 mg/kg ☐ 7 mg/kg
- ☐ 2 mg/kg

☐ **Tobramycin (NEBCIN) IV**
- ☐ 5 mg/kg
- ☐ 7 mg/kg

Antifungals

☐ **Micafungin (MYCAMINE) IV**
- ☐ 50 mg
- ☐ 100 mg
- ☐ 150 mg

☐ **Rezafungin (REZZAYO) IV**
- ☐ 400 mg
- ☐ 200 mg

Other Antimicrobials

☐ **Aztreonam (AZACTAM) IV**
- ☐ 3 g
- ☐ 6 g

☐ **DAPTOmycin (CUBICIN) IV**
- ☐ 6 mg/kg
- ☐ 8 mg/kg
- ☐ 10 mg/kg

☐ **LevoFLOXacin (LEVAQUIN) IV**
- ☐ 250 mg
- ☐ 500 mg
- ☐ 750 mg

☐ **Tigecycline (TYGACIL) IV**
- ☐ 50 mg
- ☐ 100 mg

Select Desired IM Antibiotic for Injection

☐ **Cefepime (MAXIPIME) IM**
- ☐ 1 g

☐ **CefTRIAXone (ROCEPHIN) IM**
- ☐ 250 mg
- ☐ 500 mg
- ☐ 1 g

☐ **Ertapenem-lidocaine IM**
- ☐ 1 g
- ☐ 1000 mg

☐ **Penicillin G benzathine IM**
- ☐ 2.4 million units

Select Desired Antibiotic for continuous (over 24 hours) IV Home Infusion via CADD Pump

☐ **Nafcillin (Nallpen) IV**
- ☐ 6 g
- ☐ 9 g
- ☐ 12 g

☐ **Oxacillin IV**
- ☐ 6 g
- ☐ 9 g
- ☐ 12 g

☐ **Penicillin G potassium IV**
- ☐ 12 million units
- ☐ 18 million units
- ☐ 20 million units
- ☐ 24 million units

☐ **Vancomycin (Vancocin) IV**
- ☐ 1000 mg
- ☐ 2000 mg
- ☐ 30 mg/kg

☒ ONC NURSING COMMUNICATION 5
Discontinue infusion and remove home infusion pump

☒ Discontinue PICC
May remove PICC line at the end of treatment

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ANTIBIOTICS (INTRAVENOUS/INTRAMUSCULAR) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER *(CONTINUED)*

Supplemental Orders

The following orders will be applied to the patient's plan unless otherwise indicated

Appointment Requests

☒ **Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after infusion and possible labs.

Provider Reminder

☒ **ONC PROVIDER REMINDER 20**
Routine, Until discontinued Starting when released Until Specified
Ensure that after last treatment that patient has APPOINTMENT TO REMOVE CADD pump

Safety Parameters and Special Instructions

☒ **ONC NURSING COMMUNICATION 103**
Contact Provider for increased stool production (4 or more above baseline) per day (24 hours) or moderate increase in ostomy output.

☒ **ONC NURSING COMMUNICATION 2**
Routine, Until discontinued Starting when released Until Specified
If patient has any symptoms of a hypersensitivity reaction, immediately stop medication infusion and obtain vital signs. Maintain IV patency with 0.9% sodium chloride at 10 mL/hour.

Vitals

☒ **Vital Signs**
Routine, PRN Starting when released Until Specified. Take vital signs at initiation and completion of infusion

Nursing Orders

☒ **ONC NURSING COMMUNICATION 100**
May Initiate IV Catheter Patency Adult Protocol

☒ **ONC NURSING COMMUNICATION 22**
If patient has PICC line, please draw labs from PICC line

☒ **Hypersensitivity Reaction Adult Oncology Protocol**
Until discontinued Starting when released Until Specified

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		VALIDATED:		ORDERED:		
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #
	Sign		**R.N. Sign**		**Physician Print**	**Physician Sign**

EPIC VERSION DATE: 07/16/20

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